	TMENT OF HEALTH	AND HU! I SERVICES  & MEDICALD SERVICES	454	- 915 /11	FORM	: 08/16/2011 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION (	X3) DATE S COMPLE	
		445075	B. WING _		08/1	0/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	00/1	0/2011
MADISO	N HEALTHCARE			431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 000	This Plan of Correction is the center's credible allegation of compliance.	г	
	#28259, and #2846 annual Recertificati 2011, at Madison H	ES		Preparation and/or execution of this plan of condoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and	the nclusions plan of because	
F 157 SS=D	deficiencies cited in	was substantiated with relation to the complaint 482.13, Requirements for IFY OF CHANGES (ROOM, ETC)	F 157	F157 It is the practice of this facility to immediately inform the resident; cons with the resident's physician; and if k notify the resident's legal representati an interested family member when the	nown, ve or	9-16-11
	consult with the res known, notify the re or an interested fam accident involving the injury and has the printervention; a signiphysical, mental, or deterioration in heal status in either life to clinical complication significantly (i.e., and existing form of treat consequences, or to treatment); or a decounter the resident from the §483.12(a).	ediately inform the resident; ident's physician; and if sident's legal representative nily member when there is an ne resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial hreatening conditions or is); a need to alter treatment need to discontinue an atment due to adverse or commence a new form of ision to transfer or discharge is facility as specified in		an accident involving the resident whi results in injury and has the potential requiring physician intervention; a significant change in the resident's phemental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threat conditions or clinical complications); to alter treatment significantly (i.e., a discontinue an existing form of treatment to adverse treat); or a decision to or discharge the resident from the fact specified in 4832.12(a).  Resident #19 was discharged on 7/1/2 be closer to his family. Licensed nursing supervisors will be re-educate the Staff Development Coordinator not than Sept 16, 2011 regarding notifyin physician and / or nurse practitioner of	tening a need need to nent transfer ility as 2011 to es and ed by o later g	
	and, if known, the re or interested family change in room or r specified in §483.18 resident rights unde	esident's legal representative member when there is a commate assignment as 5(e)(2); or a change in r Federal or State law or fied in paragraph (b)(1) of		facility policy regarding "Resident Exhibiting Challenging Behaviors" se attached exhibit F157 A and "Notifica see attached exhibit F157 B. The DOI ADON, nursing supervisors will reviet twenty four hour report, physician or the second supervisors.	ation" N, ew the	
BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE August 22	2, 2011	(X6) DATE
v doficion	E statement anding	alastadalı (*) danata a dağı			, , , , ,	100 100 77

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from proceeding providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN B. WING		(X3) DATE COMPL	
NAME OF PROVIDER OR SUPPLIER	445075	B. WING _		08/	10/2011
MADISON HEALTHCARE		4	REET ADDRESS, CITY, STATE, ZIP CO 31 LARKIN SPRING RD MADISON, TN 37115	ODE	
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
the address and p legal representative  This REQUIREME by: Based on medical review, and intervithe physician of a resident (# 19) of the  The findings include Resident #19 was 7, 2010, with diagral Diabetes Mellitus, Disease.  Medical record rev May 7, 2011, reveal thermometer probe intopenisbox of bedside"  Medical record rev "Resident Exhibiting revealed, "notifical symptoms"  Interview with the A (ADON) in the Direct August 10, 2011, a self-inflicted behave	ecord and periodically update hone number of the resident's e or interested family member.  ENT is not met as evidenced a record review, facility policy ew, the facility failed to notify change in behavior for one wenty-one residents reviewed.  Ided:  admitted to the facility on April closes including Hypertension, and Peripheral Vascular  iew of a nurse's note dated aled, "discovered an oral ecover inserted for probe covers discovered at iew of the facility policy for g Challenging Behaviors ation of physician of behavior  Assistant Director of Nursing office on the facility failed to notify the ior was a change for resident the facility failed to notify the	F 157	This Plan of Correction is the center allegation of compliance.  Preparation and/or execution of this does not constitute admission or agre provider of the truth of the facts alleg set forth in the statement of deficience correction is prepared and/or execution is required by the provisions of fed.  F157 Continued  and medical records during the Clinical Meeting to ensure pronotification of changes (injury etc.). The DON, ADON, Nursi will complete the "Review of Measures — Notifying Family, and Resident Change of Conductate Change of Ch	plan of correction rement by the seed or conclusions ries. The plan of seed solely because seral and state law.  The morning oper superior of superior of supervisors of su	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 2 of 18

#### DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	150 300		PLE CONSTRUCTION	(X3) DATE S	
			A. BU				
NAME OF F	200/4050 00 00000	445075	D. VVII	NG _		08/1	0/2011
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	55	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
F 157 F 250 SS=D	complaint # 28259	ISION OF MEDICALLY		157 250	This Plan of Correction is the center's a allegation of compliance.  Preparation and/or execution of this plates and constitute admission or agreen provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal	an of correction nent by the or conclusions . The plan of solely because	
	services to attain or	ovide medically-related social r maintain the highest l, mental, and psychosocial resident.			F 250 It is the practice of this facility to medically-related social services maintain the highest practicable	to attain or	9-16-11
	by: Based on medical review, and intervie obtain mental healt behavior had develof twenty-one resident #19 was a 7, 2010, with diagnor Diabetes Mellitus, a Disease.	ed: admitted to the facility on April oses including Hypertension, and Peripheral Vascular			mental, and psychosocial well-be resident. Resident # 19 was disc 7/01/2011 to another facility clos family. Members of the Interdisc Team (MDS Coordinator, Social Director, DON, and ADON) will residents coded 1, 2, or 3, in MD EO200 Behavioral Symptom – P Frequency and all orders coded "(indicating an order for psyche se been received) to ensure services rendered timely no later than 9/1 Medical Records Clerk will bring orders to the Clinical Morning M review by DNS, ADNS, and Nur Supervisors to ensure physician of	eing of each harged ser to his siplinary Service review all S section resence and PY" ervices has have been 6/2011. The g phone leeting for sing orders are	
	May 7, 2011, reveal thermometer probe intopenisbox of bedside"  Medical record revienote dated June 8, 2 consult d/t (due to) tech (technician) ca	ew of a nurse's note dated led, "discovered an oral cover inserted probe covers discovered at ew of the Nurse Practitioner's 2011 revealed "Staff request recent incident 6/6/11 in which ught resident sticking his urethra, which has			carried out timely. The DON, AI Nursing Supervisors, Social Serv will review monthly 10% of resid records coded "PY" to ensure ser rendered timely monthly for threuntil no discrepancies are noted. Service Director will report audit along with any corrective actions facility Performance Improvement Committee (Executive Director,	rice Director lents rvice are e months or The Social findings to the	

#### DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445075	B. Wil	۷G		08/1	0/2011
	PROVIDER OR SUPPLIER  N HEALTHCARE			4:	REET ADDRESS, CITY, STATE, ZIP CODI 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	also had prior incideremarks toward state though specific incident though specific incident though specific incident though specific incident the specific incident to the specific incident to the specific incident to the specific incident the	ents of inappropriate sexual ff and fondling other residents, dents are not charted."  ew revealed a physician's ted June 9, 2011 stating, ist for counseling r/t (related xual behaviors."  ew of the facility policy # PRO t Exhibiting Challenging d, "8. Notifify mental health  ocial Services Director on 1:30 p.m., in the dining area, y delayed in obtaining mental	F 2	250	This Plan of Correction is the center's callegation of compliance.  Preparation and/or execution of this plat does not constitute admission or agreen provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal F250 Continued  Operations Mgr, Dietary Manage Staff Development Coordinator, Director, Social Service Director Housekeeping/Laundry Supervis Medical Director) at its monthly review and recommendations as and needed monthly for three mountil no further discrepancies are	an of correction ment by the I or conclusions The plan of solely because al and state law.  er, ADON, Activity  or, and meeting for indentified onths or	9-16-11
F 279 SS=D	to develop, review a comprehensive plar. The facility must deplan for each reside objectives and timel medical, nursing, ar needs that are identical assessment.	CARE PLANS  ne results of the assessment  nd revise the resident's	F 2	79	See page \$ ef 18 for	on (Copy)	

## DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		445075	B. WII			00/4	0/2011
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115		] 08/1	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	Comment of the	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER CORRECT PROVI	OULD BE	(X5) COMPLETION DATE
F 279 SS=D	happened on a pre- also had prior incic remarks toward stat though specific incomedical record revitelephone order, da "Refer to psychological to inappropriate sea."  Medical record revisions for "Resider Behaviors" revealed professional"  Interview with the Saugust 10, 2011, a confirmed the facility health services for complaint # 28259 483.20(d), 483.20(d), 483.20(d) COMPREHENSIVE A facility must use to develop, review comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, a	evious occasion. Patient has lents of inappropriate sexual aff and fondling other residents, idents are not charted."  iew revealed a physician's ated June 9, 2011 stating, gist for counseling r/t (related exual behaviors."  iew of the facility policy # PRO at Exhibiting Challenging d, "8. Notifify mental health  Social Services Director on at 1:30 p.m., in the dining area, ity delayed in obtaining mental the resident.  k)(1) DEVELOP E CARE PLANS  the results of the assessment and revise the resident's		2250	This Plan of Correction is the center's created allegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged of set forth in the statement of deficiencies. Correction is prepared and/or executed so it is required by the provisions of federal of the assessment to develop, revise revise the residents comprehensive care. Resident #19 was discharged 2011 to be closer to his family. Met the Interdisciplinary Team (MDS Coordinator, Social Service direct and ADON) will review all resident 1, 2, or 3 in MDS section EO200 If Symptom – Presence and Frequent order coded "PY" (indicating an opsyche services has been received plan of care has been updated to rechange in behavior or condition not september 15, 2011. The Medical Clerk will bring phone orders and records of residents with phone or change of condition noted on the thour to the Clinical Morning Meet review by DNS, ADNS, and Nurs Supervisor to ensure the residents Care has been updated to reflect cibehavior. The DON, ADON, Nurs Supervisors, Social Service Direct MDS Coordinator will review mo of resident records coded "PY" us "Review of Process Measures – Note that the control of the process Measures – Note the provision of the provision of the process Measures – Note the provision of the provision of the provision of the process Measures – Note the provision of the p	of correction on the by the resolutions. The plan of lely because and state law.  the results ew and e plan of lend on July 1, embers of lend	9-16-11
	The care plan must to be furnished to a	t describe the services that are attain or maintain the resident's			Behaviors" PI tool (see attached e F279A) to ensure the plan of care	xhibit	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 4 of 18 A

# DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445075	B. WI	NG_		08/	10/2011
	PROVIDER OR SUPPLIER  N HEALTHCARE			4	REET ADDRESS, CITY, STATE, ZIP CODE 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including tunder §483.10(b)(4)  This REQUIREMENT by: Based on medical review and interview the care plan to reflone resident (#19) or reviewed.  The findings included Resident #19 was a 7, 2010, with diagnot Diabetes Mellitus, a Disease.  Medical record review May 7, 2011, reveal thermometer probe intopenisbox of bedside"  Medical record review "Resident Exhibiting revealed, "update Interview and medical Assistant Director of conference room or conference ro	physical, mental, and eing as required under ervices that would otherwise (483.25 but are not provided is exercise of rights under the right to refuse treatment).  In the right to refuse treatment of the record review, facility policy of the facility failed to update ect a change in behavior for of twenty-one residents of the residents of the facility on April of the right of the facility on April of the right of the facility policy for the facility polic	F	279	This Plan of Correction is the center's crediballegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement is provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and F279 Continued  updated to reflect change in behavior condition monthly for 3 months or use further discrepancies are noted. The Service Director will report audit fir along with any corrective actions to facility Performance Improvement Committee (Executive Director, DNO perations Mgr, Dietary Manager, Astaff Development Coordinator, Ac Director, Social Service director, Housekeeping / Laundry Supervisor Medical Director) at its monthly methree months or until no further discrepancies are noted for review a recommendations as identified and	r or ntil no Social adings the ADON, tivity	9-16-11

### DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	*	445075	B. WING _		08/10/2011	
	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 131 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	ULD BE	(X5) COMPLETION DATE
F 279 F 281 SS=D	updated to reflect the	ne change in behavior.  VICES PROVIDED MEET	F 279 F 281	Preparation and/or execution of this plan of does not constitute admission or agreemen provider of the truth of the facts alleged or	of correction to by the conclusions The plan of ely because	
	This REQUIREMENT by: Based on medical and interview, the fasturations as orde (#16) and the facility were secure for one residents reviewed.  The findings included Resident #16 was a 20, 2011, with diagrate Tracheostomy, Can Laryngectomy, Chropisease, and history Medical record reviet for Respiratory /Pul with the admission revealed an order for saturation) /pulse or Interview with the Dithe conference roor p.m., revealed the rethree shifts per 24	ed: Idmitted to the facility on July Roses including		It is the practice of this facility to pand arranges services that meet prostandards of quality. The procedure documenting the oxygen saturation Resident #16 was changed August to be recorded on the Medication Administration Record in place of Sign Sheet. August 10, 2011 licens caring for Resident #16 were re-edithe DON on proper documentation oxygen saturations and following porders. The Staff Development Codwill re-educate licensed nursing sta 9/16/2011 regarding following "Ph Orders For Respiratory/Pulmonary and proper documentation. The Me Records Clerk will audit 10% of the records for residents with orders to oxygen saturations monthly for the or until no further discrepancies are ensure compliance. Discrepancies are ensure compliance. Discrepancies are ensure to form the sense of Nursing her error in lead medications on the resident's over and walking into the bathroom. Dir Nurses re-educated Licensed nurse regarding proper medication admir and expectations of compliance. The Development Coordinator will re-educated proper medication admir and expectations of compliance.	ofessional e for s for 10, 2011 the Vital ed staff ucated by of ohysician ordinator off by yysician's Care" edical e medical obtain ee months e noted to will be August 9, with ving bed table rector of #2 nistration ne Staff	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 6 of 18

# DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445075	B. WIN	IG_		08/1	0/2011
	N HEALTHCARE			4	REET ADDRESS, CITY, STATE, ZIP COD 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Saturation level after Observation on Augrevealed the reside physical therapy wh gerichair.  Observation reveals humidified oxygen as a Tracheostomy tube Velcro straps.  Medical record revision of Nursing 10, 2011, at 9:15 a. to obtain and documelevel from July 29 urof 11 days.  Resident #12 was a January 19, 2011, where Weakness, Mellitus, and Altered Observation on Augther resident's room, Nurse (LPN) #2 cruvitamin, placed the plastic soufflé cups, resident's room to a Continued observation the plastic soufflé citable, walked into the then walked outside the hallway to wash	r July 29, 2011. gust 9, 2011, at 3:45 p.m., nt in the room receiving ile sitting upright in a  ed the resident was receiving at 35% by trach collar; and had be secured by a neck collar via  ew and interview with the in the DON's office on August m., confirmed the facility failed nent an oxygen saturation ntil August 10, 2011; a period  dmitted to the facility on vith diagnoses including History of Falls, and Diabetes	F 2	281	This Plan of Correction is the center's allegation of compliance.  Preparation and/or execution of this planes not constitute admission or agreed provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal licensed nursing staff no later the on policy and procedure of "Med. Administration" PRO 62002. See exhibit F281 A. The Staff Devel Coordinator will complete the "Pass Observation Review" (see a exhibit F281 C) on all newly him nurses within 90 days and all oth nurses every six months. The Staff Development Coordinator will refindings along with any corrective the facility Performance Improved Committee (Executive Director, Operations Mgr, Dietary Manage Staff Development Coordinator, Director, Social Service Director Housekeeping /Laundry supervise Medical Director) at the its month for three months or until no furth discrepancies are noted for revier recommendations as identified and the state of the state	an of correction ment by the d or conclusions s. The plan of solely because al and state law.  an 9/16/2011 dication e attached opment Medication attached ded licensed aer licensed aer licensed aer licensed aer licensed aer licensed aer, ADON, Activity sor, and hly meeting aer awand	9-16-11

### DEPARTMENT OF HEALTH AND HU! | SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLI IDENTIFICATION NI		(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		445075	B. WING	Ĺ	08/1	0/2011	
	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZII 431 LARKIN SPRING RD MADISON, TN 37115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 322 SS=D	Interview with LPN room, on August 9 the LPN left the mexited the room, le unsupervised. 483.25(g)(2) NG TRESTORE EATING Based on the compresident, the facility who is fed by a narreceives the approto prevent aspiration of preventian and nasal-pharyng possible, normal experience of the findings included the	#2 outside the resident's , 2011 at 8:42 a.m., confirmed edications at the bedside and eaving the medications  REATMENT/SERVICES - G SKILLS  prehensive assessment of a y must ensure that a resident so-gastric or gastrostomy tube epriate treatment and services on pneumonia, diarrhea, ion, metabolic abnormalities, real ulcers and to restore, if ating skills.  INT is not met as evidenced  record review, observation, w and interview, the facility aff raised the head of bed for ation for one (#12) resident eding, of twenty-one residents  led:  admitted to the facility on with diagnoses including, History of Falls, and Diabetes	F 28	Preparation and/or execution of does not constitute admission or provider of the truth of the facts set forth in the statement of defic correction is prepared and/or ex- it is required by the provisions of	f this plan of correction of agreement by the alleged or conclusions ciencies. The plan of executed solely because of federal and state law.  Cility to ensure that maso-gastric or the appropriate prevent aspiration iting, dehydration, and nasalestore, if possible, ast 9, 2011 LPN #2 feeding to Resident of Nursing that she 30-45 degrees. Reducated the ation of medication al feedings. The inator will relater than y and procedures feeding to Resident of PRO 22 A) and "Enteral PRO 6001-01 B). The Staff of will complete for proper feedings on annually. The inator will Enteral Feeding I monthly for three	9-16-11	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 8 of 18

## DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445075	B. WING _		08/1	0/2011
	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP C 131 LARKIN SPRING RD MADISON, TN 37115		0.2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323 SS=D	(nasogastic) tube". Review of the physi "Elevate HOB (head all times during feed minutes after the feed Review of the facilit Administration" polithead of the bed 30- feeding"  Observation on Aug the resident room, in bed. Continued of Licensed Practical I the enteral feeding nasogastric tube (tu Observation reveale syringe into the NG complete volume of NG tube. Continued LPN failed to elevat degrees.  Interview with LPN aroom, on August 9, the HOB was not ele and not for 30-45 m prevention of aspira 483.25(h) FREE OF HAZARDS/SUPERV  The facility must ense environment remain as is possible; and ele	cian's orders revealed, d of bed) to 30-45 degrees at ding and for at least 30-45 eding is stopped."  y's "Enteral Feeding cy revealed, " Elevate the 45 degree angle during  gust 9, 2011, at 8:35 a.m., in revealed resident #12 lying flat observation revealed Nurse (LPN #2) administered to the resident via the libe from nose to stomach). ed, LPN #2 placed a 60 ml tube and administered the enteral feeding fluid into the dispersion revealed the enteral feeding fluid into the enteral feeding fluid into the dispersion revealed the enteral feeding fluid into the enteral feeding fluid into the dispersion revealed the enteral feeding fluid into the enteral fluid into the en	F 323	Preparation and/or execution of the does not constitute admission or an provider of the truth of the facts all set forth in the statement of deficie correction is prepared and/or execution is prepared and/or execution is required by the provisions of facts all sets of the provisions of facts and the provision of fact	re fed by a naso- The SDC will crepancies and DON, SDC, and daily rounds to residents is ort audit findings tions to the ement tor, DNS, Plant mager, ADON, tor, Activity ector, ervisor, and thly meeting for ner eview and ed and needed.	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 9 of 18

## DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		445075	B. WING _		08/10/2011	
	ROVIDER OR SUPPLIER  N HEALTHCARE		4	REET ADDRESS, CITY, STATE, ZIP CODE 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	This REQUIREMENT by: Based on medical facility investigation the facility failed to place for one (#14) reviewed.  The findings include Resident #14 was a March 7, 2011, with Congestive Heart FL1-L2 Fracture with Dementia.  Medical record revied dated June 6, 2011, severe cognitive impassistance with one mobility, transferring dressing, toileting, pruther review reversexperienced a fall by Medical record revied Assessment dated I resident was at high Medical record revied investigation, reveal 12, 2011, resulting in the facility of the second revied investigation, reveal 12, 2011, resulting in the facility of the second revied investigation, reveal 12, 2011, resulting in the facility of the second revied investigation, reveal 12, 2011, resulting in the facility of the second revied investigation, reveal 12, 2011, resulting in the facility of the second revied investigation, reveal 12, 2011, resulting in the second revied investigation, reveal 12, 2011, resulting in the second revied investigation, reveal 12, 2011, resulting in the second revied investigation, reveal 12, 2011, resulting in the second revied investigation, reveal 12, 2011, resulting in the second revied investigation, reveal 12, 2011, resulting in the second revied investigation reveal 12, 2011, resulting in the second revied revied review reveal 12, 2011, resulting in the second review	record review, review of a observation, and interview, ensure a safety device was in of twenty-one residents  ed:  dmitted to the facility on History of Osteoporosis, ailure, Diabetes Mellitus, Vertebroplasty, and  ew of the Minimum Data Set revealed the resident had pairment; required extensive person physical assist for g, ambulating in the room, personal hygiene and bathing aled the resident had oth with and without injury.  ew of the Admission Nursing March 7, 2011, revealed the risk for falls.  ew and review of a facility ed the resident fell on April in a skin tear; was discharge by; and was referred to	F 323	This Plan of Correction is the center's created allegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed so it is required by the provisions of federal action is required by the provisions of federal action is region of the residents environment remains accident hazards as is possible; and resident receives adequate supervisions assistance devices to prevent accided August 10, 2011 Resident # 14 was assessed by the Director of Nursing further need of a personal tab alarm resident when in bed. It was determined the resident no longer needed the awhile in bed. The care plan and C.I. plan was updated to reflect change #14 was placed on the "Falling State Program". The Nursing Supervisor monitor residents with assistance deprevent accidents to ensure the developtace as ordered during daily round monthly for three months until not discrepancies are noted. They will immediately address any discrepance report to the DON. The Interdiscip Care Plan Team (DON, MDS Coor Activity Director, Registered Dieti Social Service Director) meet week review and update residents on the Star Program to ensure their plan of interventions, supervision and assist devices are maintaining an environ is as free of accident hazards as possible and accident hazards as possible	ensure that as free of deach sion and lents. s reg for n on mined that darm N.T. care. Resident are swill devices to vices in disfurther acies and oblinary redinators, tian, kly to Falling of care stance ament that	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 10 of 18

#### DEPARTMENT OF HEALTH AND HU! | SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445075	B. WIN	√G _	if	08/1	0/2011
	N HEALTHCARE			43	EET ADDRESS, CITY, STATE, ZIP CODE 31 LARKIN SPRING RD IADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	100000	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Medical record revithe resident was for wheelchair, with a control of Further review reversintervention was to when in bed and with Review of the x-ray revealed "chronic fracture status possis abnormality, osteod Medical record reviting March 18, 2011, re "ahistory of falls with deficits, decreased to)balance/gait and transfer and ambul review revealed an 2011, "personal transfer and ambul review revealed the reside Further observation on Augrevealed the resident in the bed. Interview with Certi August 10, 2011 at room, revealed the resident from the bed morning. Further in resident did not have attached to the resident the bed prior to the	ew revealed on April 27, 2011, und on the floor in front of the complaint of right hip pain. ealed the immediate add a personal tab alarm heelchair.  I dated April 27, 2011, healed proximal right femure to ORIF, no acute osseous arthritis"  ew of the care plan initiated on vealed a problem of with hip fracture, cognitive physical mobility r/t (related to unsteadyattempt to ate unassisted" Further approach added on May 12, ab alarm onbed  gust 10, 2011, at 8:30 a.m., nt in bed eating breakfast. In revealed no alarm was to make a transferred the red to the wheelchair this of the wheelchair the red an alarm on the bed or dent when the resident was in	F	323	This Plan of Correction is the center's creatilegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged on set forth in the statement of deficiencies. It correction is prepared and/or executed so it is required by the provisions of federal of the plan of care and C.N.T. plan of updated by MDS Coordinator to rechanges. The DON, ADON, and N Supervisors will monitor compliant following care plan interventions of providing an environment that remistee of accident hazards as is possificated resident receives adequate surand assistance devices to prevent a during daily rounds. The DON will any findings of non-compliance along the facility performance Improvement Comment (Executive Director, DNS, Plant Comply Manager, ADON, St. Development Coordinator, Activity Social Service Director, Housekee /Laundry supervisor, and Medical at its monthly meeting for three mountil no further discrepancies are resident as the control of the facility o	of correction at by the conclusions. The plan of lely because and state law.  of care is effect any fursing ace of for lains as ble, and pervision accidents. I report ong with cy ittee operations aff y Director, ping Director) onths or	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 11 of 18

#### DEPARTMENT OF HEALTH AND HUN 'SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING			
		445075	B. WING	3	08/1	0/2011	
	ROVIDER OR SUPPLIER N HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 328 SS=D	Manager on August conference room, care-planned to havin bed and while in interview confirmed the safety device with a safety devices: Injections; Parenteral and enteron and enteron a safety devices: Injections; Parenteral and enteron a safety devices: Injections; Parenteral and enteron a safety devices: Injections; Parenteral and enteron and enteron a safety devices.  This REQUIREMENT by: Based on medical review of facility polification and prostheses.  This REQUIREMENT by: Based on medical review of facility polification and prostheses.  The findings include Resident #16 was a 20, 2011, with diagram and prostheses.	t 10, 2011 at 10:48 a.m., in the confirmed the resident was we a personal tab alarm when the wheelchair. Continued the facility failed to ensure as in place.  IENT/CARE FOR SPECIAL  sure that residents receive and care for the following  eral fluids; stomy, or ileostomy care; it.  INT is not met as evidenced record review, observation, icy, and interview, the facility ff performed sterile tracheal #16) of twenty-one residents ed:  admitted to the facility on July moses including	F 32	This Plan of Correction is the center's crallegation of compliance.  Preparation and/or execution of this plandoes not constitute admission or agreem provider of the truth of the facts alleged set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federal	ensure that a and care and state law.  ensure that a and care and care and care and care and state law.  Output  Ou	9-16-11	
AL-50-910-5111L							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 12 of 18

# DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445075	B. WII	NG _		08/1	0/2011
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTHCARE				4	REET ADDRESS, CITY, STATE, ZIP CODE 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) ;	ULD BE	(X5) COMPLETION DATE
F 328	Observation on Augrevealed the reside Observation revealed humidified oxygen a a Tracheostomy with a neck collar via Verevealed the resider ight and mouthed okay?" The resider were loose.  Observation revealed (LPN #1) was in the suction (the resider unsterile gloves and (suction device use mouth) which was a gown, and inserted tube until resistance and applied suction secretions. Observe the Yankauer in a consecretion of the Yankauer in a cons	gust 9, 2011, at 3:45 p.m., and sitting upright in a gerichair. and the resident was receiving at 35% by trach collar; and had the a Tracheal tube secured by elero straps. Observation and moved head from left to fro" when asked "are you at's cough indicated secretions and stated, "I will at)." The LPN #1 donned at picked up the Yankauer at to remove mucus from the attached to the resident's the Yankauer into the tracheal as was met ("3/4 of an inch"); to remove a small amount of ation revealed the LPN #1 put up of water to clear the laced the Yankauer on the attached to the resident's room at 4:12 p.m., revealed the mount of ation revealed as the Yankauer to one from the oral cavity.  #1 outside the resident's room at 4:12 p.m., revealed the following from the oral cavity.  #2 policy number PRO 66309 or Care, revealed a sterile (containing sterile gloves, rerile catheter) was required the procedure was to be	F	328	This Plan of Correction is the center's creallegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged of set forth in the statement of deficiencies. Correction is prepared and/or executed so it is required by the provisions of federal of the fact of the fact of the provisions of federal of the fact of the	of correction at by the resonance of correction at by the report of lely because and state law.  It ress any on. The ll report ective of lar, ping Director, ping Director) onths, or officient	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 13 of 18

## DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE S COMPLE	
		445075	B. WING _		08/1	0/2011
	PROVIDER OR SUPPLIER N HEALTHCARE		4	REET ADDRESS, CITY, STATE, ZIP 431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 328	verified the Yankau oral secretions (not confirmed the facilituse a sterile suction the tracheal tube to suctioning.  483.35(i) FOOD PFSTORE/PREPARE  The facility must - (1) Procure food froconsidered satisfacility authorities; and	n August 9, 2011, at 5:10 p.m., per suction was to be used for a for tracheal suctioning), and try policy was for the LPN to a catheter that would fit into a allow for appropriate, deeper ROCURE, //SERVE - SANITARY  om sources approved or story by Federal, State or local distribute and serve food	F 328	Preparation and/or execution of a does not constitute admission or a provider of the truth of the facts a set forth in the statement of deficic correction is prepared and/or executive is required by the provisions of	this plan of correction agreement by the alleged or conclusions iencies. The plan of ecuted solely because if federal and state law.  Ility to I)Procure d or considered atte or local repare, distribute ary conditions.  Was immediately e call to check the ne and correct spense appropriate attive instructed egistered Dietician od. The Dietary	9-16-11
	by: Based on observation sanitizer recommer compartment sink, dietary department and utensils per the recommendations a dietary equipment.  The findings include Observation on Aug 10:50 a.m., with the revealed the following.  The three comparison of the sanitized of the following.	and interview, the facility failed to sanitize pots, pans manufacturer's and failed to maintain sanitary ed:  gust 8, 2011, beginning at Registered Dietitian present,		staff on the proper dispensi directed by Echo Lab. 8/09 pan and back splash on the cleaned by the Cook. 8/19/2010 the RD and DM staff meeting to re-educate regarding cleaning schedul dispensing of sanitizer and follow schedule and disper Failure for staff to follow particles for staff to follow particles and to disciplinary actions including termination. The updated the daily cleaning include specific task and particles (See addendum 371 / A) Total control of the con	o/2011 the spill a stove were  If held a dietary the staff le and proper accountability to using method, procedure for y conditions will a up to and a DM and RD schedule to person responsible.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 14 of 18

#### DEPARTMENT OF HEALTH AND HU' I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION						
		445075	B. WIN	1G _		08/1	0/2011
	PROVIDER OR SUPPLIER  ON HEALTHCARE			43	REET ADDRESS, CITY, STATE, ZIP CODE 31 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371	control serving uter dietary items on the observation revealed checking the sanitizer revealed the quater colors (indicating in 2. The four burner splash had a heavy blackened debris. 2011, at 7:48 a.m., confirmed the range splash had a heavy blackened debris.  Review of the three sanitizer level record quaternary chemical 400 parts per million. Interview, with the Fidietary department a.m., and on Augus confirmed the quater color indicating the 150 parts per million Further interview comaintain the dietary sanitary manner. 483.75(I)(1) RES RECORDS-COMPLE  The facility must mare resident in accordant standards and practice.	nsils in the sanitizer sink and e drain board. Further ed the dietary staff member zer level. Further observation many test strip did not change is sufficient level of sanitizer).  range top, spill pan, and back accumulation of sticky, Observation on August 9, with the Registered Dietitian, e top, spill pan and back y accumulation of sticky,  e compartment sink poster for mmendation revealed the al sanitizer level was 150 to in.  Registered Dietitian in the on August 8, 2011 at 10:50 at 9, 2011, at 7:48 a.m., ernary test strip did not change sanitizer level was less than in for sanitizing equipment. In a confirmed the facility failed to a department/equipment in a suffice that are complete; inted; readily accessible; and		371	This Plan of Correction is the center's created allegation of compliance.  Preparation and/or execution of this plan a does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. It correction is prepared and/or executed solit is required by the provisions of federal and responsible for cleaning the spill passplash, and stove at the end of their The Cook will be responsible for cleaning the "Sanitizer Log" each shift. (See addendum 371/B) The DM will be responsible for utilizing the PI Nutroservices: "Quick Rounds" tool five a week for one month or until substantiance has been achieved and adherence to policy and procedures days a week thereafter. The RD will weekly rounds with the DM utilizing Nutrition Services: "Quick Rounds weekly. The ED will complete the Nutrition Services: "Quick Rounds weekly. The ED will complete the Nutrition Services "Quick Rounds two weeks with the RD and DM un compliance is maintained for one monthly and randomly thereafter. The will report the results of these PI to with any corrective and/or disciplinaction to the facility performance improvement committee (Executive Director, DNS, Plant Operations M Mgr, ADON, Staff Development Coordinator, Activity Director, Soc Service Director, Housekeeping/Las Supervisor, and Medical Director) amonthly meeting for review and recommendations as identified and	of correction at by the conclusions The plan of lely because and state law.  an, back a shift, hecking the conclusions from the constantial determine to the cons	9-16-11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 15 of 18

#### DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445075	B. WIN			08/1	0/2011
	PROVIDER OR SUPPLIER		-J.	43	REET ADDRESS, CITY, STATE, ZIP COD 31 LARKIN SPRING RD 1ADISON, TN 37115		0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	0.0	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE PPROPRIATE	(X5) COMPLETION DATE
F 514	information to iden resident's assessm services provided; preadmission scre and progress note:  This REQUIREME by: Based on medical and interview, the medical records for residents reviewed.  The findings included Resident #2 was a 20, 2007, and readwith diagnosis included Accident with Hemmaliure, and Histor Review of the pharagune 3, 2011, revenience has monthyou wish to continuother lab work order Further review revente recommendation months" dated Jun Review of the physical, 2011, revealed.	must contain sufficient tify the resident; a record of the nents; the plan of care and the results of any ening conducted by the State; s.  INT is not met as evidenced record review, policy review, facility failed to have accurate r two (#2, #18) of twenty-one l.  Ided:	F	514	This Plan of Correction is the center's allegation of compliance.  Preparation and/or execution of this places not constitute admission or agree provider of the truth of the facts alleg set forth in the statement of deficiencic correction is prepared and/or execute it is required by the provisions of feder 5514  It is the practice of this facility clinical records on each resider accordance with accepted profestandards and practices that are accurately documented; readily and systematically organized. A 2011 a clarification order was a correct the July 2011 Recapitul Physician Order to reflect the colliantin Level every six month #2. The Medical Records Clerk clarification order to ensure the order was correct. The DON, A Medical Records Clerk and Nu Supervisors will audit 10% of Recapitulation of Physician or "OL" (orders for lab) to ensure medical records monthly for the until no further discrepancies a August 9, 2011the Executive D Medical Records Clerk and Dis of Clinical Operations reviewed and procedures for Closing a M Record PRO 13105. Effective if the Medical Records Clerk will procedures as outlined in the C Medical Record, The Director of Operations will review 3 discharmonthly for three months or until no further discrepancies of Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedures as outlined in the C Medical Records Clerk will procedure as outlined in the C Medical Records Clerk will procedure as outlined in the C Medical Records Clerk will procedur	to maintain at in essional ecomplete; accessible; August 9, written to lation change for as for Resident accuracy of ree months or re noted. Prector, strict Director d the policy fedical immediately follow losing a of Clinical arged charts	9-16:11

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 16 of 18

#### DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
ACCES 12		445075	B. WING		08/1	0/2011	
	ROVIDER OR SUPPLIER		43	EET ADDRESS, CITY, STATE, ZIP CO 31 LARKIN SPRING RD IADISON, TN 37115	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 514	Review of the July Order signed by a and signed by the revealed "Dilantin Interview with the 9, 2011, at 2:25 p. confirmed the Jun agreement with the did not match the Continued intervier Recapitulation Physician Cirrhosis, Jaundic record review revels discharged to home health.  Medical record resummary was not the physician.  Review of the facing Record revealed completed and cloth discharge17. Of Administrator and (discharge) summary completed for the discharge	2011 Recapitulation Physician facility nurse on June 29, 2011, physician on July 11, 2011, level monthly."  Director of Nursing on August .m. at the north nursing station, se 21, 2011, physician e pharmacy recommendation June 21, 2011, phone order. Ew confirmed the July 2011 ysician Order did not reflect the thly to every six month dilantin each admitted to the facility on May gnosis including New Onset erebrovascular Accident, se, and Alcohol Abuse. Medical realed the resident was ne on June 10, 2011, with home exiew revealed the Discharge to completed; and not signed by lity policy "Closing a Medical "resident's medical record is used within 30 days after btain the signatures of both the Medical Director on the mary19. Review the discharge ted by the attending physician	F 514	This Plan of Correction is the center allegation of compliance.  Preparation and/or execution of this does not constitute admission or agr provider of the truth of the facts alle set forth in the statement of deficient correction is prepared and/or executit is required by the provisions of fed.  F514 continued  discrepancies are noted. The I report her findings to the Executive Director will refindings for Closing a Medicathe DON will report on audit along with any corrective actifacility Performance Improve Committee (Executive Direct Operations Mgr, Dietary Man Staff Development Coordinat Director, Social Service Direct Housekeeping /Laundry super Medical Director) at its month three months, or until no furth discrepancies are noted, for rerecommendations as identified	plan of correction eement by the ged or conclusions ries. The plan of the solely because deral and state law.  DDCO will cutive Director. eport audit I Record and for lab orders ons to the ment or, DNS, Plant tager, ADON, or, Activity ctor, rvisor, and only meeting for the eview and	9-16-11	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BKKQ11

Facility ID: TN1915

If continuation sheet Page 17 of 18

## DEPARTMENT OF HEALTH AND HUI 'SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

If continuation sheet Page 18 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
		445075	B. WING		08/1	0/2011
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTHCARE			43	ET ADDRESS, CITY, STATE, ZIP 1 LARKIN SPRING RD ADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 514	Operation on Augu conference room, of	ege 17 st 9, 2011, at 9:50 a.m., in the confirmed the physician failed iled to sign the discharge	F 514	at the second se		
				ir Os		
z.						

Facility ID: TN1915

Event ID: BKKQ11